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Payment Group

Principals

Thomas W. Coons

Leslie Demaree Goldsmith

Carel T. Hedlund

S. Craig Holden

Julie E. Kass

Paul W. Kim (Counsel)

Robert E. Mazer

Christine M. Morse

Laurence B. Russell

Susan A. Turner

Associates

Kristin C. Cilento

Joshua J. Freemire

Donna J. Senft

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CMS Releases Final Rule Limiting the Duration of Non-Random Prepayment Complex Medical Review

Mark A. Stanley
410-347-7353
mastanley@ober.com

Relief is on the horizon for some providers and suppliers under intense scrutiny by Medicare contractors. CMS has released a final rule establishing the bases for termination of non-random prepayment complex medical review, a process that imposes significant documentation requirements on subject providers and suppliers. Under the new rule, a contractor must terminate complex medical review one calendar year after initiating such review, and must terminate the review earlier if the subject meets an error-rate benchmark.

Non-random prepayment complex medical review may be initiated, in a contractor's discretion, after the contractor determines that the subject has a sustained or high level of payment error. The initial determination of payment error is established using automated or routine processes, which do not place documentation burdens on providers or suppliers. When a contractor suspects that a provider or supplier is an appropriate target for complex medical review, the contractor must conduct a probe review of a small sample of claims to confirm that a high level of payment error is present. If a high level of payment error is confirmed, the contractor may initiate a complex medical review, which entails evaluation of medical records by a licensed medical professional applying clinical judgment. The scope and focus of the review is within contractors' discretion, and medical review is generally focused on items or services to which contractors attribute the greatest risk of improper payments. In order to facilitate complex medical review, subject providers and suppliers must submit documentation sufficient to establish medical necessity for the claims being reviewed.

Under the final rule, the duration of complex medical review may not exceed one calendar year from the date that the provider or supplier is notified of the review. If the provider or supplier decreases its initial error rate (calculated based on the dollar amount of claims) by 70% or more, the contractor must terminate the review prior to the one year deadline. The contractor determines the error rate on a quarterly basis.

A contractor may extend complex medical review beyond the one year time frame, even where the target has reduced its error rate by 70% or more, if the contractor suspects that any reduction in error rate is the product of improper billing practices. For example, if a target, with the apparent intent to avoid review, stops billing the code under review or bills under a different provider identification number, the contractor may extend the complex medical review

Mark A. Stanley

Emily H. Wein

beyond one year. A contractor may also extend complex medical review if the target fails to provide sufficient documentation to facilitate the review.

After the termination of complex medical review, a provider or supplier will face continued scrutiny. The contractor may continue to reevaluate the provider or supplier's data and, not less than six months after terminating a complex medical review, may initiate an additional complex medical review if the contractor determines that the target's billing error rate justifies such action.

The final rule can be viewed at **http://edocket.access.gpo.gov/2008/pdf/E8-22307.pdf**